2021-2023 **IMPLEMENTATION STRATEGY**

Barton Health

TABLE OF CONTENTS

IDENTIFYING SIGNIFICANT HEALTH NEEDS

About Barton Health

Barton Memorial Hospital, based in South Lake Tahoe, CA, is a not-for-profit, 111-bed hospital (acute care and skilled nursing) with a primary service area surrounding South Lake Tahoe, CA and Douglas County, NV. In addition to the hospital, Barton Health (Barton) manages more than 16 physician offices and clinic practices. With nearly 1,000 employees, Barton provides services primarily to residents of the South Lake Tahoe area, but also serves those around the Lake and Carson City as well as a large number of visitors to the area. Barton Memorial Hospital is accredited by The Joint Commission.

Barton Health's mission is to deliver safe, high quality care and engage the community in the improvement of health and wellness. The vision is to be the community health leader known for compassion and chosen for quality. Barton is committed to integrity, collaboration and excellence through the practice of our four Service Standards: Safety, Respect, Image, and Efficiency.

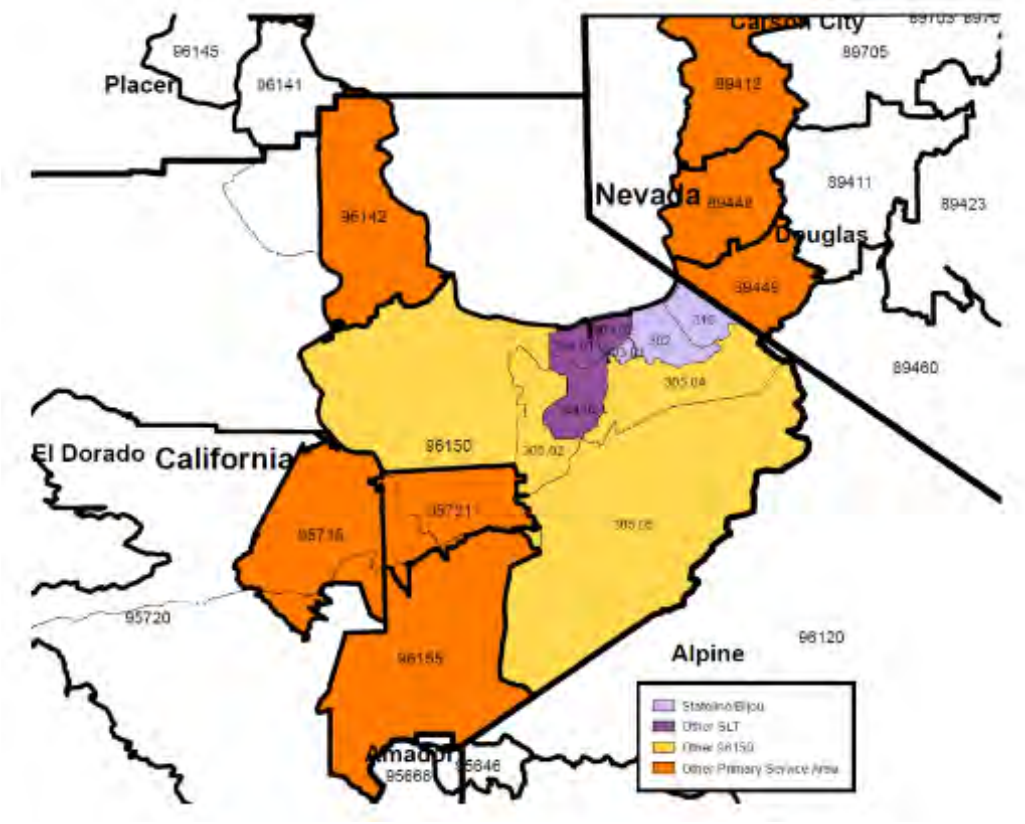
Our Community Health Needs Assessment (CHNA)

In the winter of 2021, Barton Health embarked on a comprehensive Community Health Needs Assessment (CHNA) process to identify and address the key health issues for our community.

Definition of the Community Served

The study area for the survey effort is defined as each of the residential ZIP Codes comprising the Primary Service Area (PSA) of Barton Health, including 96150, 95735, 96142, 96155, 89413, 89448, 89449, 96151, and 96158. This community definition, determined based on the ZIP Codes of residence of recent patients of Barton Health, is illustrated in the following map.

In reporting, results are further segmented to census tracts associated with the Stateline/Bijou area of South Lake Tahoe, Other South Lake Tahoe ("Other SLT"), Other 96150 ZIP Code ("Other 96150"), and Other Primary Service Area ("Other PSA").



How CHNA Data Were Obtained

The CHNA incorporated data about the community from multiple sources, including both primary and secondary data:

- A population-based survey among a representative sample of community residents (the PRC Community Health Survey)
- An online survey of public health representatives, health providers, and a variety of other community service providers and stakeholders (the PRC Online Key Informant Survey)
- A review of existing vital statistics, public health, census, and other data

The CHNA allowed for extensive comparison to benchmark data at the state and national levels.
The assessment was conducted on behalf of Barton Health by PRC, a nationally recognized health care consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994.

Identifying & Prioritizing Health Needs

Areas of Opportunity

Significant health needs (or "Areas of Opportunity") were determined in our CHNA after consideration of various criteria, including: standing in comparison with benchmark data; identified trends; the preponderance of significant findings within topic areas; the magnitude of the issue in terms of the number of persons affected; and the potential health impact of a given issue.

Prioritized List of Health Needs

After reviewing the Community Health Needs Assessment findings, internal team members and community stakeholders met to evaluate and prioritize the top health needs for our community. The participants were asked to evaluate each health issue along two criteria: 1) scope and severity of the health issue; and 2) the hospital's/community's ability to impact that issue. Individual ratings for each criterion were averaged for each tested health issue, and then these composite criteria scores were averaged to produce an overall score. This process yielded the following prioritized list of health needs for our community:

1. Access to Healthcare Services
2. Mental Health
3. Substance Abuse
4. Cancer
5. Diabetes
6. Heart Disease & Stroke
7. Infant Health & Family Planning
8. Injury & Violence
9. Nutrition, Physical Activity & Weight
10. Potentially Disabling Conditions
11. Respiratory Diseases
12. Tobacco Use

ADDRESSING THE SIGNIFICANT HEALTH NEEDS

Community Benefit Planning

This summary outlines Barton Health' plan (Implementation Strategy) to address our community's health needs by 1) sustaining efforts operating within a targeted health priority area; 2) developing new programs and initiatives to address identified health needs; and/or 3) promoting an understanding of these health needs among other community organizations and within the public itself.

Priority Health Issues to Be Addressed

In consideration of the top health priorities identified through the CHNA process — and taking into account hospital resources and overall alignment with the hospital's mission, goals and strategic priorities — it was determined that Barton Health would focus on developing and/or supporting strategies and initiatives to improve:

1. Access to Healthcare Services
2. Mental Health
3. Substance Abuse
4. Cancer
5. Diabetes
6. Heart Disease & Stroke
7. Infant Health & Family Planning
8. Injury & Violence
9. Nutrition, Physical Activity & Weight
10. Potentially Disabling Conditions
11. Respiratory Diseases
12. Tobacco Use

2021-2023 Implementation Strategy

Action Plans

The following displays outline Barton Health's plans to address those priority health issues chosen for action in the FY2021-FY2023 period.

Priority Area #1: Access to Health Care Services	
Community Health Need	Improve access to primary care and specialty providers.
Goal(s)	1. Identify access barriers to improve access 2. Expand patient-centered care models to improve standardization and continuum of care 3. Increase insurance coverage for the community through outreach for Covered California and Medi-Cal 4. Create and implement an outreach plan for the Latino Community 5. Develop plan for Stateline campus expansion
Action Plan	**Strategy 1: Identify access barriers to improve access** ● Standardize dashboard illustrating benchmarks for access including third next available, open panels, provider patient appointment volume and percentage of PCP assignments ● Increase primary care provider availability for first time patients. ● Increase appointment availability through standardizing schedules, and supporting provider efficiency ● Expand after hour appointments weekdays and weekends. ● Recruit providers, as necessary, to meet demand and expand specialty providers. ● Increase MyChart usage ● Perform analysis on community health care center expansion to better meet local needs of underinsured **Strategy 2: Expand patient-centered care models to improve standardization and continuum of care** ● Create streamlined operations across all primary care settings, to provide easier access to care through open scheduling, expanded hours, and increased options for communication between patients, their doctors, and support staff ● Improve access and care coordination through meeting criteria for the Patient Centered Medical Home (PCMH) designation at Barton Family Medicine location ● Establish PCSP designations to outpatient specialty clinics to continue care coordination **Strategy 3: Increase insurance coverage for the community through outreach for Covered California and Medi-Cal** ● Train and maintain certification for Barton Health employees to become certified enrollment counselors for Covered California ● Medi-Cal county liaison to have office space and education to staff to direct patients for enrollment ● Continue as a resource for the community to answer questions and enroll consumers into medical health coverage ● Provide educational marketing materials and ensure website has information regarding health insurance options for the South Lake Tahoe region

	Strategy 4: Create and implement an outreach plan for the Latino Community ● Work with community partners such as Family Resource Center, school districts, Lake Tahoe Community College, El Dorado County Community Hub, El Dorado County Substance Use Disorder and UC CalFresh to coordinate ideas and plans to best reach and educate this community ● Host and partner in community gathering events that best reach and serve our Latino community ● Regularly participate in parent cafecitos ● Provide timely educational articles and webinars in Spanish ● Partner with community organizations to provide direct medical resources, such as flu clinics, COVID-19 vaccinations, blood work labs, and more **Strategy 5**: **Develop plan for Stateline campus expansion**. ● Expand availability and office hours for primary care providers and specialties offices at Stateline campus ● Open outpatient MRI offering affordability and convenience, similar to other outpatient Nevada free-standing locations ● Develop and communicate long term strategy for Stateline, NV campus
Anticipated Impact	● Increase the number of patients with assigned Barton primary care providers by 1,000. ● Increase third next available appointments by two days for primary care and specialty offices. ● Increase patients attending annual wellness visits by 5% each: 5% for Medicare wellness visits and 5% for well child checks.

Priority Area #2: Mental Health	
Community Health Need	Improve the referral system and create partnerships for service providers in the community to empower and strengthen the quality of life for South Lake Tahoe residents.
Goal(s)	1. Expand and continue to provide mental and behavioral health services. 2. Spearhead community collaboration and engagement to improve the mental health care flow system. 3. Build awareness through education and prevention campaigns.
Partnering Organization(s)	Behavioral Health Network partners: El Dorado County Behavioral Health, El Dorado County Community Health Hubs, Lake Tahoe Unified School District, Tahoe Youth & Family Services, Family Resource Center, Live Violence Free, A Balanced Life
Action Plan	**Strategy 1: Expand and continue to provide mental and behavioral health services.** ● Recruit additional behavioral health providers to address behavioral health needs for patients ● Track and improve depression screening rates at annual wellness visits ● Pursue opportunities to continue tele-behavioral health treatment access for Medi-Cal/care patients through HealthNet grant or other. ● Explore ways to integrate mental and behavioral health services in primary care settings with ACES screening **Strategy 2: Spearhead community collaboration and engagement to ensure alignment of programs and support.** ● Spearhead a subcommittee of the Community Health Advisory Committee addressing actionable mental and behavioral health items.

	Host a community-wide forum focused on addressing mental health needs in the area ● Attend and facilitate regular meetings of BHN. ● Barton Health to evaluate partnering in a shared referral system. **Strategy 3: Build awareness through education and prevention campaigns.** ● Implement awareness campaign during Mental Health Awareness Month: City proclamation, green ribbons for media partners and employee badges, educational articles, advertisements, lectures/webinars, web and social media awareness ● Conduct a suicide prevention and awareness campaign and support Suicide Prevention Network's efforts ● Comprehensive mental health resources will be included in the community resource guide that is distributed out to the community and updated annually ● Community health grant resources will be allocated to services provided by local non-profit organizations to address unmet mental health needs in the community
Anticipated Impact	● Continue to increase depression screenings in primary care offices by 10%. ● Recruit one additional mental health provider and add a behavioral health coordinator to increase access to mental health services.

Priority Area #3: Substance Abuse	
Community Health Need	To reduce youth and adult substance use in the South Lake Tahoe region.
Goal(s)	1. Develop and maintain pathways addressing pain and addiction. 2. Participate in the coordinated community groups focused on substance use. 3. Conduct outreach and education on the effects of alcohol and drug use.
Partnering Organization(s)	Tahoe Alliance for Safe Kids (TASK) partners: El Dorado County Substance Use Disorder Department, Lake Tahoe Unified School District, South Lake Tahoe Police Department
Action Plan	**Strategy 1: Develop and maintain pathways addressing pain and addiction.** ● Expand the Medication Assisted Treatment program to include additional waivered providers and an Emergency Department Bridge Program as well as any supporting programs that help reduce opioid overdose ● Continue the Substance Use Navigator role to help support and coordinate care for in-patient and expand to out-patient settings. ● Support additional programs at the Community Health Center to support addiction, such as Outpatient Alcohol Abuse program-a monthly injection (Vivitrol) ● Pursue Opioid Care Honor Roll designation through the Cal Hospital Compare to increase access to addiction treatment for hospitalized patients and reduce opioid-related deaths. Part of the program includes training for healthcare professionals in opioid safety practices to prevent new opioid starts, identify and treat opioid use disorder, prevent overdose and develop an overall culture of opioid safety

	• Consider implementation of appropriate alternative therapies to patients throughout the Barton Health system including aromatherapy, integrative medicine, meditation, massage therapy and others • Utilize physiatrist + anesthesiologist for non-opioid pain management • Educate the importance of alternative pain management modalities through patient-facing collateral and articles **Strategy 2: Participate in the coordinated community groups focused on substance use.** • Attend and participate in community meetings addressing education and prevention, including Tahoe Alliance for Safe Kids, El Dorado County Opioid Coalition, and others • Support community prevention programs and fund opportunities, including Drug Store Project, DEA Drug Take Back Day and Opioid Coalition Conference Speaking Panel • Support grant funding that supports community efforts to help drive education and services for substance use **Strategy 3: Conduct outreach and education on the effects of alcohol and drug use**. • Implement awareness campaign annually through: lectures/webinars, presentations at the local schools, articles, advertisement, web and social media awareness • Substance use resources will be included in the health resource guide updated annually • Contribute time, data and other resources to further the mission of prevention and education and ensure successful program outcomes. Particular programs may include: permanent drug take back bins, in-home lock bags, an alternative suspension program at the middle and high schools, and educating parents on the dangers of alcohol and drug use for teenagers through community presentations and the Parent Texting Network • Disseminate appropriate information to Barton staff and physicians and coordinate internal trainings as requested
Anticipated Impact	• Engage more Medication Assisted Treatment (MAT) patients by adding an additional Substance Use Navigator. • Increase MAT patients by 25% of baseline, year over year.

Proposed Activities to Address Remaining Priorities	
Cancer	• Partner with Tahoe Forest Hospital to provide reliable shuttle services to and from the South Shore for patients needing cancer treatments at Gene Upshaw Cancer Center • Education in community via articles, webinars, social media regarding importance of screenings • Send out letters to patients when they are due for screenings. • Offer enhanced mammograms and medical imaging technology. • Continue partnership with UC Davis and Gene Upshaw Cancer Center • Outreach and support groups, such as 'Fighting Cancer with Your Fork' • Women's Health Screening Clinic held annually in October. • Hire new GI provider
Diabetes	• Education in the community via articles, webinars, social media regarding importance of screenings • Provider referral to dietician and nutrition classes • Provider referral to health coach to identify high-risk patients and create plan to address pre-diabetes • Promote A1C screenings for current diabetic patients
Heart Disease & Stroke	• Maintain cardiology services • Offer sleep lab referrals • Blood pressure screenings in primary care setting • Outreach programs for blood pressure control including an Anthem case management program for hypertension that helps targeted patients better understand and manage their hypertension. • Heart Safe program - AEDs throughout the community driven by Foundation campaign • Heart health lectures and education • Offer blood pressure screenings at community health fairs, including Bijou Health Fair • Care management program identifying high risk patients to improve blood pressure monitoring and control
Infant Health & Family Planning	• Partner with the school health teachers and student advocate to provide education and resources on the importance of early prenatal care. Additionally, provide education that early prenatal care is an important and routine aspect of preconception care. Educate on the signs of pregnancy, and where to access affordable diagnostic testing to confirm pregnancy early in the gestation • Work with community partners- First 5 El Dorado, Choices for Children, Tahoe Youth & Family-- to provide support and resources. • BCHC and Barton Women's Health's scheduling staff to expedite/prioritize the initial visit to ensure first trimester prenatal care
Injury & Violence	• Collaborate and support anti-violence organizations such as Live Violence Free and CASA • Participate in ACEs collaborative meeting • Social determinants and ACEs screening tools implemented in primary care setting • Brief Intervention Program implemented for admitted patients after trauma to reduce recidivism of alcohol • Maintain Mandated Reporter organization status
Nutrition, Physical Activity & Weight	• Promotion of healthy nutrition through We Can! and Harvest of the Month in partnership with CalFresh and the school district. • Provider referral to local education classes on nutrition and healthy eating • Continue Barton Wellness programs including Mediterranean Lifestyle and Fighting Cancer with Your Fork • Support local youth sporting events as well as community events that promote activity/wellness • Continue food distribution program to underserved communities

	• Community food distribution to underserved neighborhoods as well as assisting local pantries to obtain/purchase high quality proteins and fresh produce.
Potentially Disabling Conditions	• Continue outreach and education on rehabilitation and performance programs targeting community members with activity limitations and high impact chronic pain.
Respiratory Disease (COVID)	• Develop and implement a COVID Rehab program to address impairments in muscle strength, heart and lung capacity, pain, balance, endurance, and walking ability. • Ongoing education on mitigation and evolving information regarding COVID • Continue education and vaccine opportunities to at-risk populations. • Pathway to Home program to allow patients to recover safely at home • Identify and implement approved treatment programs
Tobacco Use	• Family provider to continue high school presentations on the risks of vaping. • Vaping presentations to service clubs and PTA/cafecitos. • Continue prioritizing vaping as a wellness lecture topic, targeting youth and parents. • Support Drug Store Project by filming a segment on the risks of vaping.

Implementation Strategy Adoption

On October 28, 2021, the Board of Barton Memorial Hospital, which includes representatives from throughout the South Lake Tahoe region, met to review this plan for addressing the community health priorities identified through our Community Health Needs Assessment. The Board approved this Implementation Strategy and the related budget items to undertake these measures to meet the health needs of the community.

Board Approval & Adoption:

Wendy David Barton Board Chair

Name & Title

10/28/21

Date

This Implementation Strategy document is posted on www.bartonhealth.org.